IMPORTANT INFORMATION

BR200351 DECEMBER 23, 2003

To All Providers:

- Effective January 1, 2004, Customer Assistance will return to standard business hours. These hours are Monday through Friday 8 a.m. to 12 p.m. and 1 p.m. to 5 p.m. Contact the Customer Assistance Unit by calling (317) 655-3240 in the local Indianapolis area, or 1-800-577-1278.
- Beginning in January 2004, the Indiana Health Coverage Programs (IHCP) will produce a monthly provider newsletter that will be sent to all providers. The purpose of the provider newsletter is to present program information in an easy-to-read format that is distributed on a regular basis as well as to eliminate the need for multiple provider bulletins. The provider newsletter will be printed and mailed by the 15th of each month, and providers should expect to receive copies shortly thereafter.
  While the provider newsletter will not completely replace the provider bulletins, it will significantly reduce the number of bulletins printed each year. Providers will continue to receive bulletins on topics such as the annual Healthcare Common Procedure Coding System (HCPCS) code updates, the annual diagnosis-related group (DRG) updates, quarterly drug utilization review (DUR) publications, and surveillance and utilization review (SUR) issues. Occasionally, bulletins associated with policy changes that do not fall into the time constraints of the monthly newsletter may also be sent separately to providers. Providers are encouraged to share the provider newsletters with their staff. EDS welcomes comments and suggestions for the improvement of this publication.
- Effective February 1, 2004, addresses for non-pharmacy refunds and third party liability (TPL) refunds will change. Please remit non-pharmacy refund checks to correct billing errors, to settle casualty cases, and to satisfy accounts receivables to: EDS Refunds, P.O. Box 2303, Dept. 130, Indianapolis, IN 46206-2303. All refund checks as a result of TPL billing to insurance companies should be remitted to: EDS TPL (HMS) Checks, P.O. Box 2303, Dept. 132, Indianapolis, IN 46206-2303. The address to return any non-cashed Indiana Health Care Programs (IHCP) check will remain unchanged: EDS Finance Department, 950 North Meridian Street, Suite 1150, Indianapolis, IN 46204-4288.
- This article clarifies information about the Vaccines for Children (VFC) Program that was published in the *IHCP Provider Manual*, published April 2003. The list of VFC Program vaccines in Chapter 8, Section 3, page 8-225, Table 8.73, should include the following vaccines:

Procedure Code	Description
90713	Inactivated Polio Vaccine (IPV)
90748	Hep B/Hib combination, brand name Comvax
90723	DTaP/IPV/Hep B, brand name Pedirix
90657	Influenza Virus Vaccine, split virus, 6-35 months dosage, for IM or jet injection use, per 0.25 ml
90658	Influenza Virus Vaccine, split virus, 3 years and above dosage, for IM or jet injection use, per 0.5 ml

  Current Procedural Terminology (CPT) codes 90657 and 90658 have been temporarily removed from VFC pricing due to current shortages in the vaccine. CPT code 90655 – *Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use,* CPT code 90656 – *Influenza virus vaccine, split virus, preservative free, for children and adults 3 years and up in age, for intramuscular use*, and CPT code 90660 – *Influenza virus vaccine, split virus, live, for intranasal use*, are also available for billing. Providers may bill for these vaccines according to the type of vaccine and source of the stock. VFC stock may be billed at $8 and private stock may be billed for the full amount.
  In addition, the following vaccines were listed incorrectly in the same table and should be listed as follows:

IHCP Provider Manual, April 2003	Correct
Dtap	DTaP
PCV	PCV 7

  Influenza should also be included in the list of diseases for which the VFC Program offers free vaccines. This list is contained in the *IHCP Provider Manual* Chapter 8, Section 3, page 8-226.
- On January 1, 2004, the 2004 Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) code updates will be loaded in Indiana*AIM*. Program coverage and pricing determination for the 2004 HCPCS and CPT codes will be finalized by April 1, 2004, and will be effective retroactively to January 1, 2004. Claims billed with 2004 HCPCS and CPT codes, prior to April 1, 2004, will be denied. Providers may continue to bill 2003 HCPCS and CPT codes prior to April 1, 2004. The 2004 HCPCS and CPT codes will be published in a future IHCP bulletin. This banner article does not affect the local code replacement activity scheduled to occur on January 1, 2004. Direct any questions to EDS Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area, or 1-800-577-1278.
- This article is to remind providers who bill Medicare Part B claims that all crossover claims received on the CMS-1500 form must have the combined total of the Medicare coinsurance, deductible, and psych reduction reported on the left hand side of field 22 under the heading *Medicaid Resubmission Code*. The Medicare paid amount, actual dollars received from Medicare, must be submitted in field 22 on the right hand side under the heading *Original Ref No*. CMS-1500 crossover claims received without the information in fields 22 will be returned to the provider. If this process changes you will receive advance notification.

To All Pharmacy Providers:

- Effective December 16, 2003, the State Maximum Allowable Cost (SMAC) rate for the following drug groups will be updated.

Group	Drug Group Name	SMAC
12	METHYLPHENIDATE 20MG	$0.5214
78	CYCLOBENZAPRINE 10MG TAB	$0.1778

Please direct questions concerning the SMAC to the Myers and Stauffer Pharmacy Unit by telephone at (317) 846-9521 or 1-800-877-6927, or by e-mail at pharmacy@mslc.com.

To All Anesthesiologists and Certified Registered Nurse Anesthetists:

- This is a correction to the modifiers for medical direction and certified registered nurse anesthetists (CRNAs) billing requirements published August 15, 2003, in the IHCP provider bulletin *BT200353*.
  CRNAs must use anesthesia CPT codes (00100-01999) and bill with the appropriate modifier. The table below lists the only modifiers that can be used by CRNAs. One of the anesthesia procedure code modifiers listed in the table below must be reported to identify services rendered by the CRNA and the anesthesiologist providing medical direction.
  HCPCS modifier, *AD – Medical supervision by a physician: more than four concurrent anesthesia procedures*, should not be used for services rendered by an anesthesiologist when providing medical direction. According to *405 IAC 5-10-3 (i)*, reimbursement is available for medical direction of a procedure involving an anesthetist only when the direction is by an anesthesiologist, and only when the anesthesiologist medically directs two, three, or four concurrent procedures involving qualified anesthetists.

Modifier	Description
QS	Monitored anesthesia care service
QX	CRNA service: with medical direction by a physician
QZ	CRNA service: without medical direction by a physician
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals

To All Waiver Providers:

- The national codes and modifiers for **dates of service January 1, 2004, and after** shown on the *Notice of Action* from the case manager are the only codes that will be accepted by the IHCP on CMS-1500 claim forms or the 837P electronic transactions. The local codes, starting with W through Z, replaced by the national codes will not be valid for **dates of service after December 31, 2003.**

- Effective for dates of service January 1, 2004, replacement level I (CPT) or level II (national) codes must be used instead of local level III codes. Claims submitted with dates of service on or after January 1, 2004, with local codes and local code modifiers will deny.

To All Home Health Providers:

- Rates for several codes published August 15, 2003, in the IHCP provider bulletin *BT200353*, have been changed. The following table provides the code, description, and rate for each code affected.

Local Code	Rate	National Code	Rate
Y0601 – Skilled nursing, LPN, RN, by visit	$28.76	99600 – Unlisted home visit or service. TD - RN	$27.51
X3069 – Licensed practical nurse, hourly	$23.05	99600 – Unlisted home visit or service. TE - LPN/LVN	$22.28
Y0501 – Home health, assistant, nurse's assistant, orderly, by the visit	$14.13	99600 – Unlisted home visit or service	$14.10
W6503 – Physical therapy, individual; by the unit; modalities not requiring use of capital equipment.	$14.48	G0151 – Services of physical therapist in home health setting, each 15 minutes. This code should only be used in a home health setting.	$13.76
W7402 – Occupational therapy, by the unit, individual	$74.02	G0152 – Services of occupational therapist in home health setting, each 15 minutes. This code should only be used in a home health setting.	$13.56
W9083 – Speech therapy, home health	$14.76	G0153 – Services of speech and language pathologist in home health setting, each 15 minutes. This code should only be used in a home health setting.	$12.58

To All Federally Qualified Health Centers and Rural Health Clinics:

- Effective for all claims received December 17, 2003, for date of service April 1, 2003, and after, all Federally Qualified Health Centers (FQHC) and rural health centers (RHC) can bill place of service codes 32 and 50 on the paper CMS-1500 claim form or the 837P electronic claim format.